Report of the

Wisconsin Medicare Reimbursement Summit

From the Office of

Governor Scott McCallum

October 2002

Executive Summary

In 2000, set against a backdrop of dramatically rising health insurance premiums for small employers and insurers beginning to leave certain small group markets, the Small Employer Health Insurance Task Force was created. Chaired by Insurance Commissioner Connie L. O'Connell, the task force was charged with examining the deteriorating conditions of the small group market and making recommendations for its improvement.

One immediate and inescapable conclusion of the five task force meetings was the adverse impact on Wisconsin employers, insurers and providers of geographic payment disparities within the federal Medicare program. Wisconsin and other upper Mid-western states have traditionally been paid less per Medicare enrollee due to efficient, low-cost management of the program. If Wisconsin received Medicare payments at the national average, an additional **$1 billion** in payments would flow to the state. The practical result of this public payment shortfall is that the deficit is shifted by Wisconsin health providers onto private commercial insurers, thus contributing to rising premiums.

The task force recommended, among other things, that the Governor convene a Medicare Reimbursement Summit, co-hosted by all stakeholders that share a goal of eliminating or mitigating the Medicare inequity. On April 29, 2002, stakeholders representing hospitals, physicians, insurers, nursing homes, other health care providers, and state government, gathered in Madison to examine issues related to Medicare reimbursement inequities affecting Wisconsin. The goals were to raise awareness among state policymakers, and the general public, about the significant problems facing Wisconsin due to payment disparities within the Medicare system and to develop a unified message to send to Wisconsin's Congressional delegation and Medicare policymakers in Washington, D.C.

The Medicare Reimbursement Summit was moderated by Wisconsin State Journal Associate Editor Thomas W. Still and featured U.S. Representative Paul Ryan, Sue Rohan from the Centers for Medicare and Medicaid Services, Cobalt Corporation Chairman and CEO Thomas Hefty, Dr. Susan Turney of the Wisconsin Medical Society, and Steve Brenton of the Wisconsin Health and Hospital Association (WHA). The summit also featured presentations by WHA's George Quinn, Tim Size of the Rural Wisconsin Health Cooperative (RWHC), John Smylie of Security Health Plan and Dr. Turney. Wisconsin Department of Health and Family Services Secretary Phyllis Dubé delivered a welcoming message from Governor Scott McCallum.

The archaic and complex federal Medicare reimbursement formula rewards Medicare providers in areas with high historic health costs while penalizing those providers in low-cost areas for the same services. The federal government's across-the-board Medicare cuts included in the 1997 Balanced Budget Act took equal percentages from both high payment and low payment states. Additional cuts to Wisconsin's already low payments resulted in negative Medicare margins for many hospitals. Cost-effective, low-utilization states like Wisconsin have little or no ability to absorb additional cuts through greater efficiencies.

Another practical result of this payment inequity is that Wisconsin's senior citizens are denied access to the broad range of affordable benefits and services that senior citizens in many other states enjoy. For example, in places where medical costs are high, such as Florida, reimbursement rates are high enough that Medicare HMOs can offer their plans without a premium. Unfortunately, the Medicare population in Wisconsin has limited access to HMO care due to insufficient Medicare payments.

Although ultimately dismissed, the State of Wisconsin filed a lawsuit against the federal government in 2000 to end the discrimination against Wisconsin's elderly. The lawsuit alleged that the wide disparities in Medicare managed care rates violated constitutional clauses relating to equal protection and the right to travel. The suit was intended to force Congress to develop a funding system that will dispense equal benefits regardless of geography so that Medicare HMO payments would no longer be based on past Medicare spending in various regions.

This report illustrates the significant negative impact that continual underfunding has and will have on the health care system in the state and the economy of Wisconsin. The message is clear-- the federal government must reexamine the current Medicare system and make substantive changes to reduce inequities. It is also clear that stakeholders in Wisconsin must be more aggressive in pursuing these changes. Wisconsin hospitals, healthcare providers, insurers, employers, and labor unions must stand united in their effort to ensure that Wisconsin receives the support it deserves.

The Badger State can no longer afford to be a "donor" state -- contributing its fair share to the federal program, but receiving fewer benefits and reimbursements in return. Wisconsin must enlist other states that are similarly situated to broaden the equity message and speak with a louder voice so that Washington listens and acts.

The Medicare Challenge Facing Wisconsin

The federal Medicare program plays a dominant role in health care in our society. Most notably, the federal Medicare program provides the framework for all health care services for more than 40 million senior citizens. The Centers for Medicare and Medicaid Services (CMS) reported Medicare expenditures in excess of $200 billion in 2000. In combination with Medicaid payments made to states, the federal government is the largest health care purchaser in the nation.

When enacted by Congress in 1965, the Medicare program was based on the principal of equity for the nation's senior citizens regardless of place of residence. This principal required that beneficiaries receive identical benefits throughout the country and that providers would be fairly compensated for services provided.

In the 35 years since Medicare was enacted, massive inequities have developed in the program, which have placed large numbers of providers and beneficiaries at a severe disadvantage. These inequities have developed as a result of a number of factors, which include:

- Pervasive incentives for high-cost areas of the country
- Pervasive disincentives for low-cost areas of the country
- Politically motivated gerrymandering in areas of the nation designed solely to maximize receipt of federal dollars
- Outdated and complex formulas that fail to reflect economic realities.
- Reliance on old data that fails to reflect changes in health care delivery

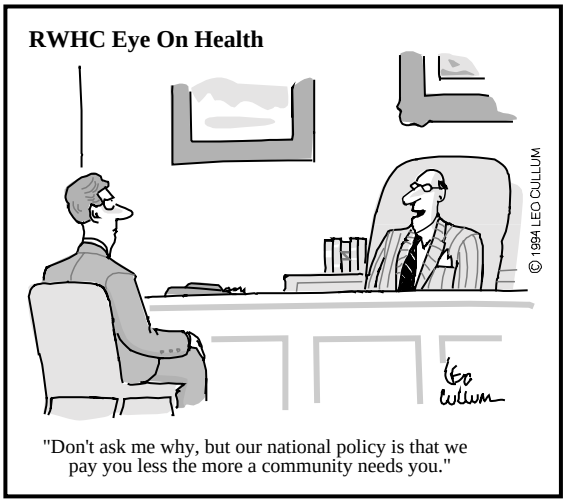
Medicare's influence extends beyond its beneficiaries and spending levels, also affecting the health care costs of other consumers. In the case of most private insurance, providers negotiate reimbursement levels with the insurer, or the insurer calculates provider payments based on market payment levels. However, Medicare determines what their reimbursement will be to any provider based on strict formulas. As the formulas have not been updated to reflect changes in market conditions, geographic payment disparities have developed . Underpayments within the program force hospitals, physicians, and other providers to shift their losses from Medicare patients and services to private-pay consumers. The regional payment disparities within Medicare financing only exacerbate this cost shifting, causing a substantial and negative impact on Wisconsin's employers, consumers, and health care industry.

Over the 35 years that the Medicare payment and distribution formula has been in existence, massive inequities have developed that create disadvantages for all patients, providers, and insurers in Wisconsin. When the Medicare reimbursement formulas were originally developed, health care costs in Wisconsin were low compared to other states. Health care costs in the Midwest today, and particularly in Wisconsin, are among the highest in the nation. According to the consulting firm of Hewitt Associates, in 2001 the average projected cost of health care per worker was $4,707 in the United States, while in

Milwaukee, that cost was projected to be $5,393. Yet, the reimbursement mechanism has not been adjusted to reflect this change. The Balanced Budget Act of 1997 worsened the problem by limiting the growth in Medicare spending. In 1998, total Medicare spending per beneficiary averaged $5,465. Medicare spending per beneficiary in Wisconsin for the same year was $4,241. ***If the total amount of Medicare spending per beneficiary in Wisconsin rose to the national average, an additional one billion federal dollars would flow into Wisconsin.*** And despite more recent efforts to bring fairness to the system through the Benefits Improvement Act of 2000 (BIPA), huge inequities still remain.

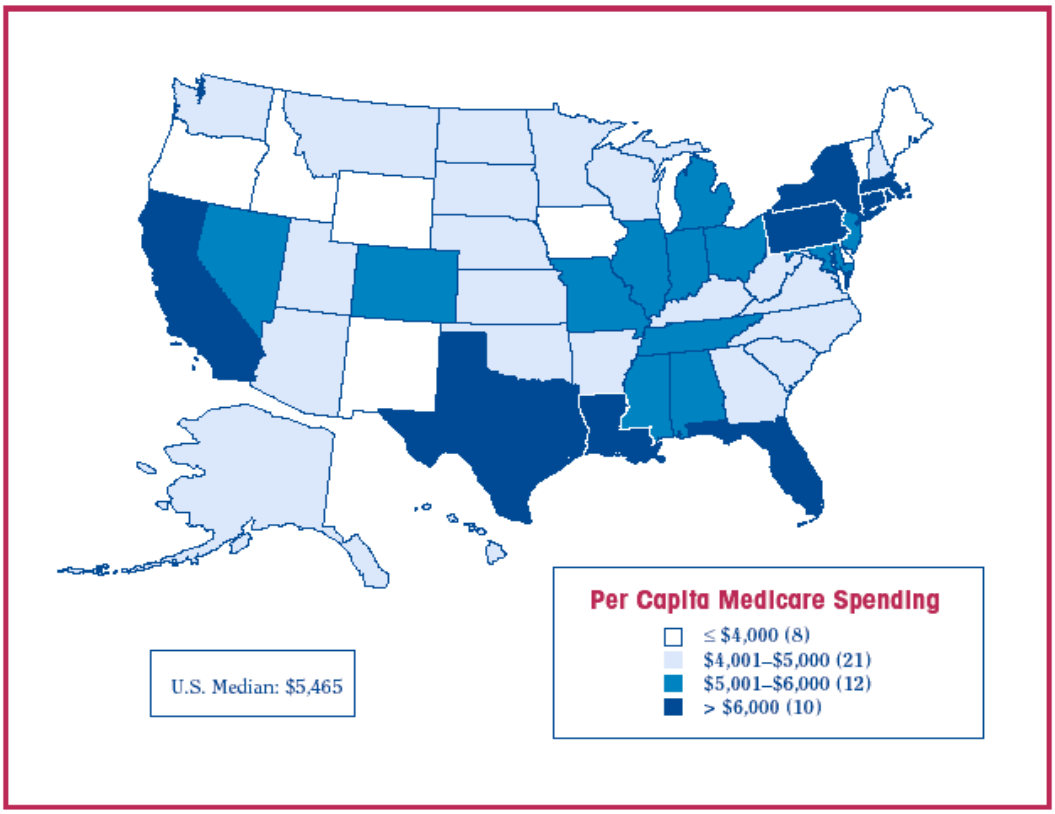
Impact Of Medicare Shortfall Hits Us All

- Patients
- Community
- Employers
- Payers
- Healthcare:
  - Workers
  - Professionals
  - Hospitals
  - Clinics



Rural Wisconsin Health Cooperative

The scope of the Medicare reimbursement inequities can only be appreciated by viewing Wisconsin's position relative to the other, more fortunate states. The Kaiser Family Foundation, in its *2001 Medicare Chart Book*, paints a bleak picture for Wisconsin. Based on 1998 data, Wisconsin ranks 39th in total Medicare spending per beneficiary (SPB) at 77% of the national average SPB. The state that ranked lowest, New Mexico, was 68% of the national average. However, since New Mexico has far fewer Medicare beneficiaries (232,164) than Wisconsin (794,789), their total funding inequity is $397 million compared to $972 million for Wisconsin. The map below, from the Kaiser Family Foundation publication *Medicare State Profiles 1999,* illustrates the distribution of Medicare funds across the United States



Source: Health Care Financing Administration, 1998. Kaiser Family Foundation

Other states, such as Florida, New York, Texas, Louisiana and California have Medicare SPB well in excess of the national average of $5,465 per beneficiary. Louisiana ranked highest among the states with $7,246 SPB or 32% above the national average, followed by Texas ($6,781, +24%), Florida ($6,564 +20%), New York ($6,436, +17%), and California ($6,035, +10%). It is no coincidence that these states also have large Congressional delegations and/or key committee representation.

Medicare's Impact on Hospital Payments

The Medicare program pays hospitals for services on a fixed price basis, modified by local labor costs. This method is meant to reward efficient providers, but even low-cost providers, such as those in Wisconsin, are paid significantly less than their costs. **Wisconsin's hospitals are paid 11% less than their costs – in fact, Wisconsin ranks 45th nationally in percent of costs paid for providing services to Medicare beneficiaries.** On average, hospitals nationwide are paid their full costs. The impact of this inequity threatens the viability of Wisconsin's hospitals, and denies its citizens a fair return on their tax dollars.

$1 Billion Annual Wisconsin Medicare Shortfall

Medicare CY 1998	Rural WI Enrollees	Urban WI Enrollees	All WI Enrollees
# Enrollees	236,000	482,000	768,000
Payment/ Enrollee/Year	$3,694	$4,361	$4,108
(Loss) Compared To USA Avg. = $5,299	($1,605)	($938)	($1,191)
(Loss) To WI	($459M)	($452M)	($911M)

Data: *Medicare/Medicaid Statistical Supplement, 2000*

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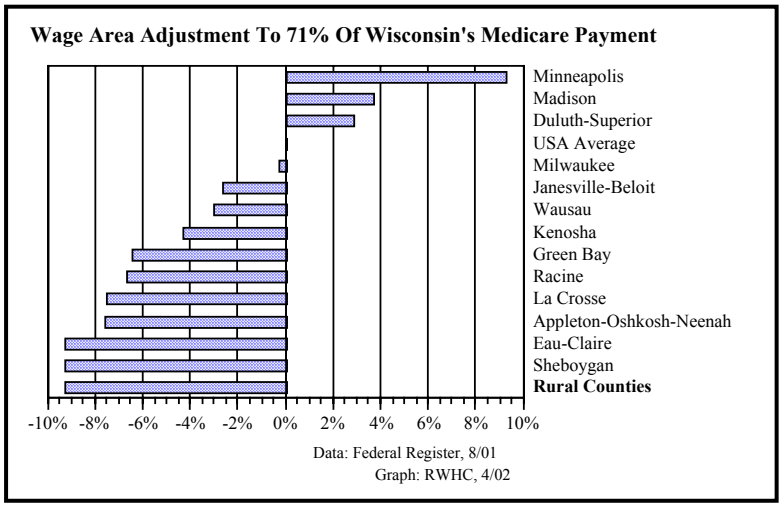
While the payment system for Medicare appears fair and equitable, politics has played a large part in enhancing the formula to the advantage of some states at the expense of others. Two elements of Medicare's payment formula are unfair and largely responsible for the payment inequities outlined above. They are as follows:

Medicare base payment rate: Medicare payments for in-patient hospital services, referred to as Diagnosis Related Groups (DRGs) are based on a standard national rate that is adjusted to reflect local wage differences (using a wage index) and which takes into account the acuity, or severity, of the patient's illness. However, large metropolitan areas (with populations over one million) receive a **1.6% higher base rate** than all other areas of the country. This differential has been in existence since the beginning of the DRG payment system. Since local cost differences are already accounted for with the wage index, and no data exists to justify other cost differences, the 1.6% higher rate penalizes most Wisconsin hospitals because of their geographic location. **Equalizing this payment amount would add $18 million annually in higher payments to Wisconsin hospitals.**

The Medicare Wage Index: The wage index is the factor that has the greatest impact on payment differences around the country, and it is also the greatest source of inequity. The index is deeply flawed in both its development and in its application in the formula.

Medicare Wage Index Self-Fulfilling Prophecy



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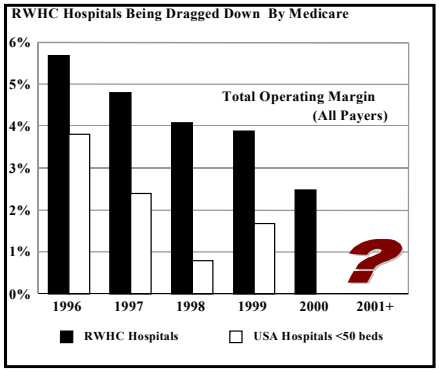
The main concern with the index is that it is applied too great a percentage of the DRG payment. The adjustment factor is applied to 71% of costs, while wages comprise a much lower percentage of costs in the typical hospital – closer to 55% in Wisconsin. By applying the area wage index to an inappropriately high percentage of costs, the Medicare program is underpaying hospitals with lower indexes. Because most of Wisconsin's area wage indexes are less than 1.00, (compared to New York City, for example, that has a wage index of 1.40), Wisconsin hospitals receive lower payments than they should. **Typically, this means several hundred dollars of underpayment for each Medicare admission, or over $15 million annually for Wisconsin hospitals.**

The best solution to the wage index problem would be to apply the index to the actual portion of costs that are wage-related. This, however, would be an expensive solution. Another possible solution would be the creation of a wage index floor of .925. This floor would improve Medicare payments for some Wisconsin hospitals, and provide a more equitable payment environment throughout the Medicare payment system.

Rural hospitals are particularly disadvantaged because Medicare enrollees typically constitute over 50% of rural hospitals costs. In addition, rural hospitals have lower Medicare in-patient margins than urban hospitals and the gap has widened from less than one percentage point in 1992 to almost 10 percentage points in 1999.

RWHC Bottom Lines Increasingly Negative

Medicare enrollees typically constitute over 50% of a rural hospital's costs.



USA Data: *MedPAC Report To The Congress*, 3/02

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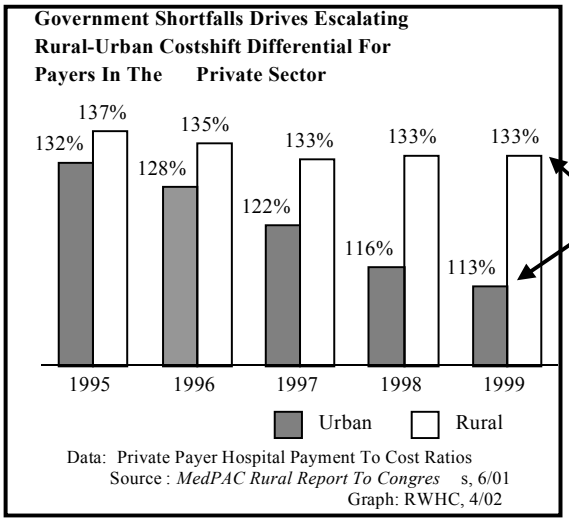
Cost Shift Hitting Rural Private Payers Harder



Rural Asked To Absorb A Cost Shift 2 1/2 Times Larger Than Urban

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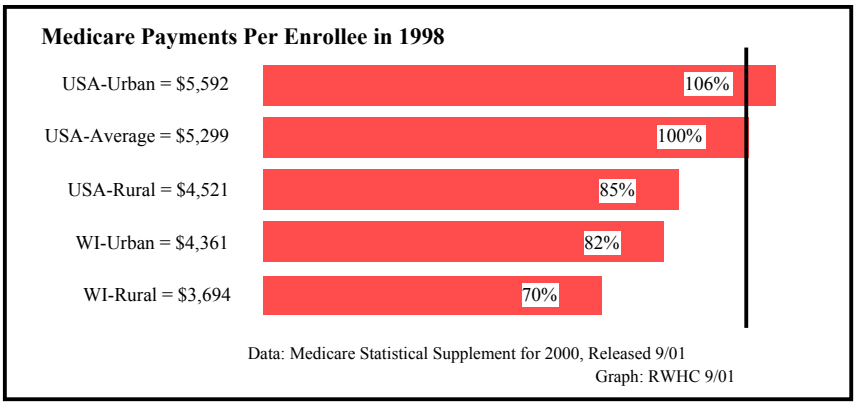
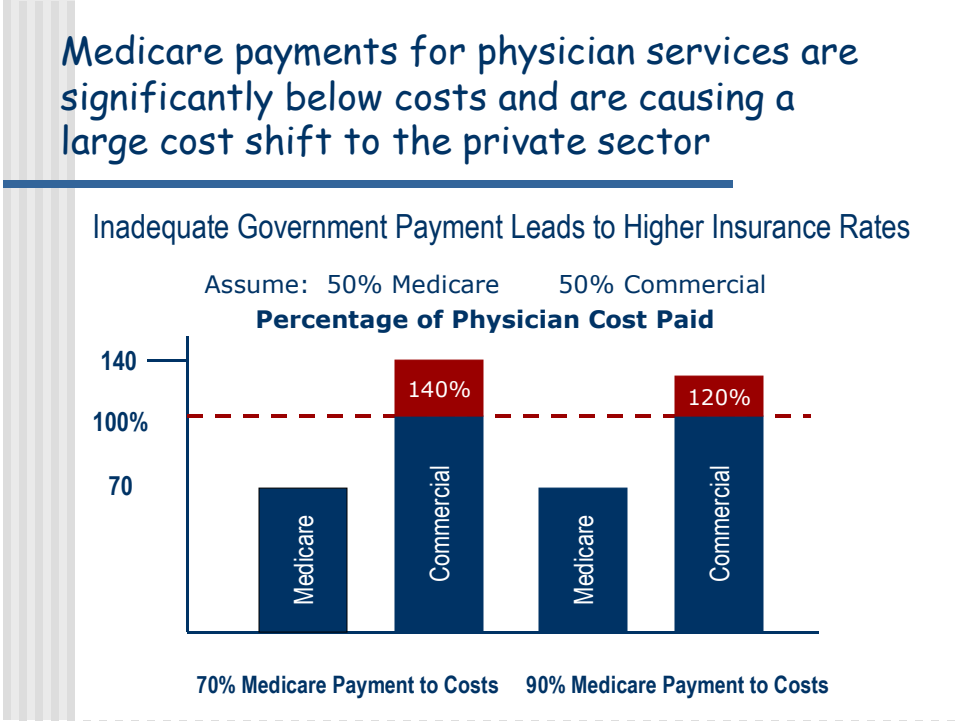
Shortfall: WI Urban Bad, WI Rural In Cellar



Rural Wisconsin
Health Cooperative

Medicare's Impact on Physician Payments

As shown by the example in the chart below, physician payment shortfalls from Medicare increase the costs that must be charged to consumers and private insurance payers.



There are several fundamental factors that contribute to the physician payment problem that creates regional and national disparities. First is the Sustainable Growth Rate (SGR) that was created as a budget neutrality principle to control Medicare Part B spending.

A second fundamental factor is the Geographic Practice Cost Index (GPCI) which adjusts physician Medicare payments regionally on three basic expense factors — a physician's work, overhead, and malpractice cost. GPCI values are calculated by CMS for 89 different payment areas. The entire State of Wisconsin is one GPCI area. The index itself clearly establishes disparities, relying on decennial census data that quickly becomes obsolete in the current environment of rapidly changing provider costs. Even more egregious, the GPCI component related to malpractice is based on a survey of premiums conducted by CMS and has the widest range of values from .279 to 2.738 which, in essence, punishes Wisconsin for having a stable malpractice insurance market with low premium rates. Clearly, the GPCI formula is one of the most glaring parts of a reimbursement formula that punishes quality and efficiency.

The third fundamental factor is the system of "Resource Based Relative Values " (RBRVs) that tries to assure that all services are paid at the same cost rates, without assuring that payment is adequate. Unfortunately, RBRVs are not sensitive to an aging population, the shift of service provisions from in-patient to out-patient care, and the increases in technology and new services. As a result, Medicare reimbursement of providers falls far short of the cost of producing services.

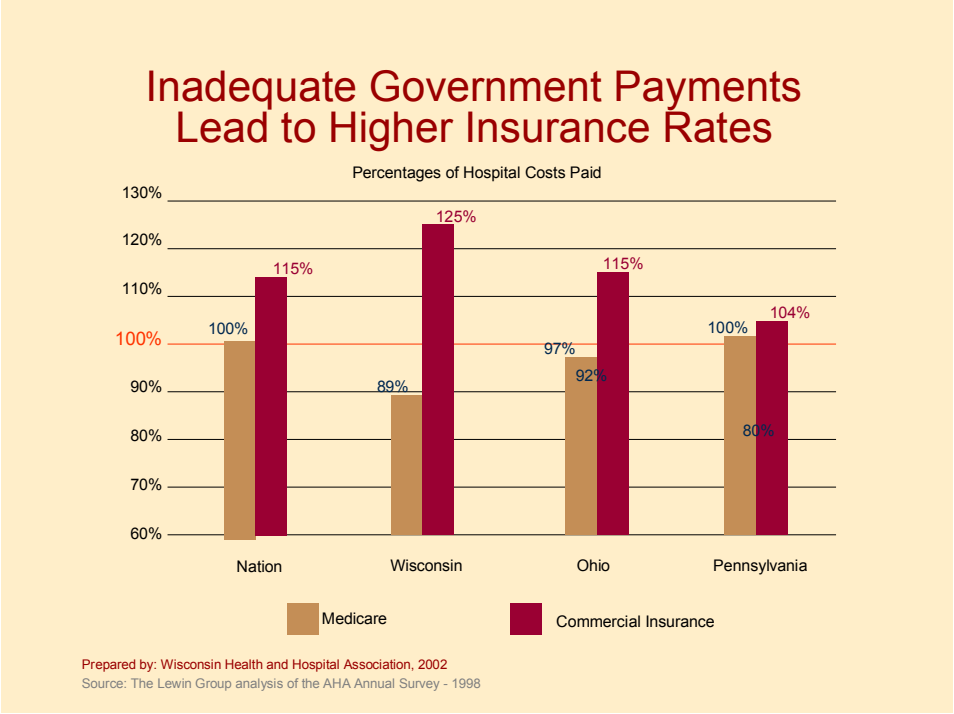
Medicare reimbursement of physicians falls far short of the cost of producing services

- Recent analysis at Marshfield Clinic demonstrated Clinic recovers approximately 70% of its costs in providing Part B services

Year	Medicare Revenue as a % of cost
2000	71.52
2001	70.59
2002	68.50

Medicare Payment Inequities and the Effect on Health Insurance

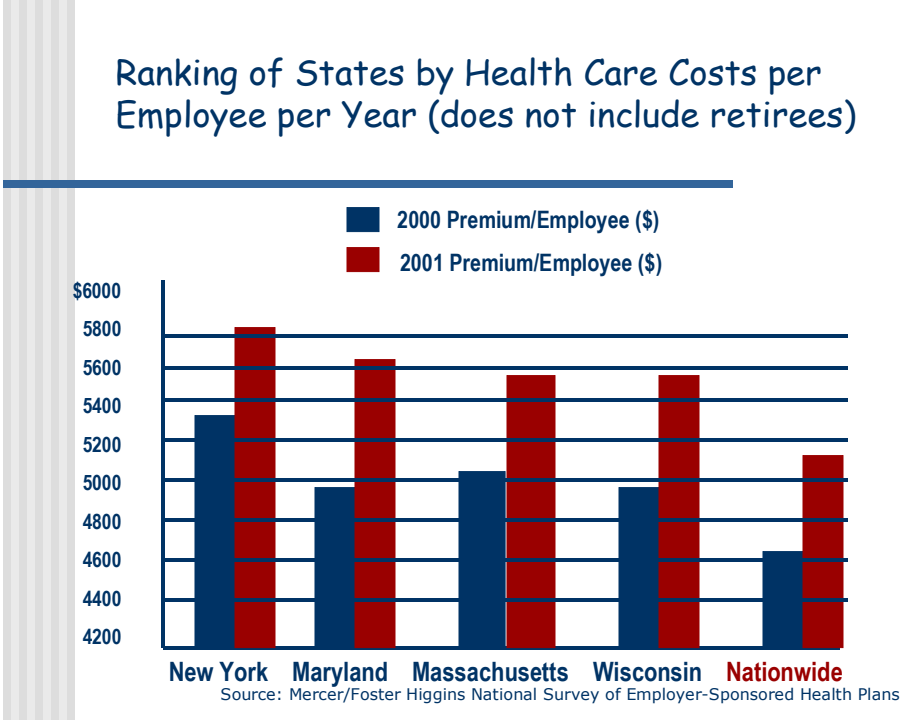
The underfunding of Medicare and the unfunded costs accumulated by Medicare providers are made up by shifting costs to private payers, either private pay clients or commercial insurance. As the table below clearly shows, Wisconsin private payer charges are significantly higher than the national average, while their percentage of Medicare reimbursement for costs is significantly below the national average. Unfavorable Medicare reimbursement forces them to cost shift to the private market.

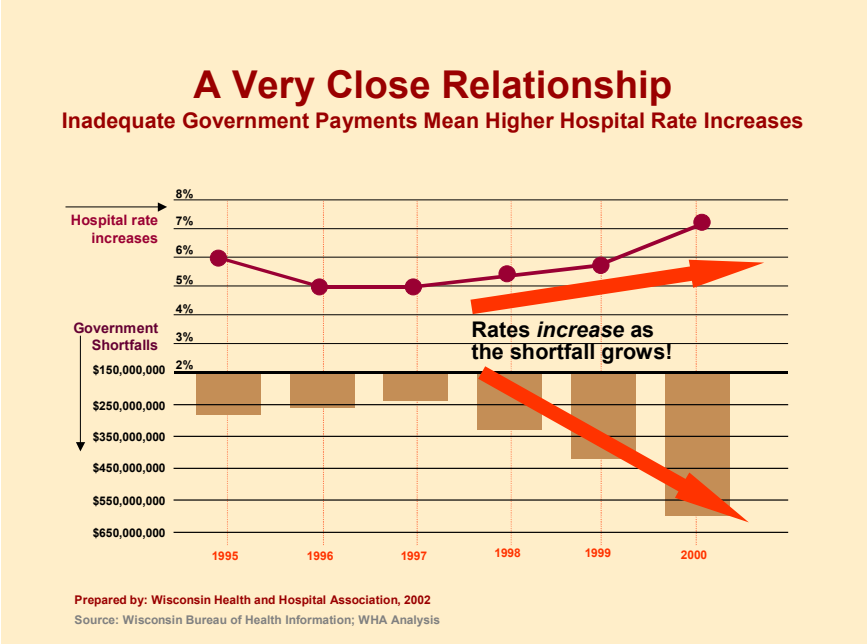


Medicare's Overall Impact on Wisconsin Employers and Consumers

Current inequities in the way Medicare reimburses hospitals, physicians, and other health care providers have had a dramatic and negative impact on the health care costs in Wisconsin. Inadequate Medicare reimbursement results in cost shifting that raises the cost of care for the remainder of the health care system to make up for shortfalls in Medicare reimbursements.

Wisconsin taxpayers pay the same payroll deductions for Medicare, and receive the same basic Medicare benefits as the rest of the country. Yet, because Wisconsin providers receive less Medicare compensation than providers nationally, citizens of the state are paying more to offset the shortfall, especially through higher health insurance premiums. The following table compares the premiums the states with the highest health care costs per employee to the national average. As noted, only New York, Maryland and Massachusetts had higher health care costs per employee than Wisconsin.





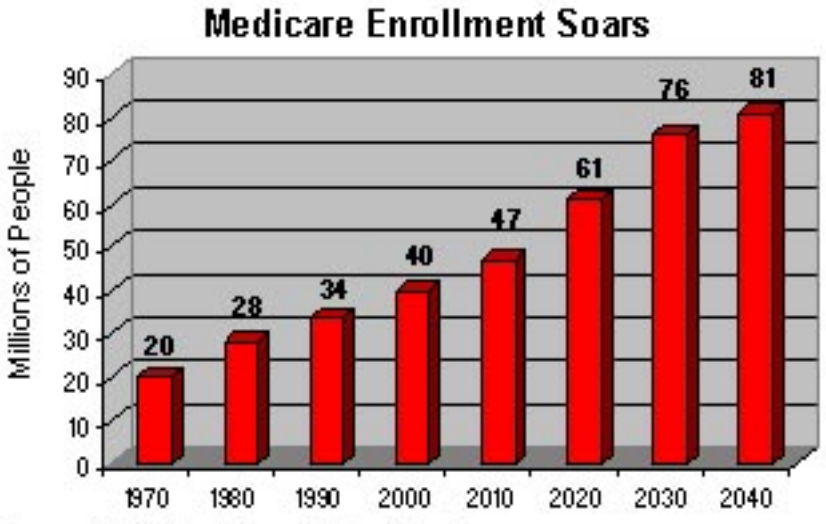
Another demonstration of the Medicare reimbursement formula's effect on insurance premiums was revealed by the actuarial consulting firm of Milliman USA in its 2001 HMO intercompany rate survey. Similar to the statewide Group Insurance Index prepared by the Office of Commissioner of Insurance, the survey asks health plans to submit their manual rates for a defined group with common characteristics and a common set of benefits. The survey showed that in a apples-to-apples comparison, Wisconsin insurance premiums are 2nd highest in the nation, following North Carolina, which also happens to be a state that is punished by the Medicare reimbursement formula. States that benefit from the reimbursement formula have lower health insurance premiums

HMO Intercompany Rate Survey

	Rank	Total Manual Premium pmpm	%Wisconsin Over
North Carolina	1	$216.54	
Wisconsin	2	214.46	
Florida	15	177.84	20.6
Louisiana	23	163.05	31.5
California	27	148.69	44.2

The Medicare program will only be further strained as the nation's elderly population increases. For Wisconsin seniors, this means having fewer Medicare covered benefits and fewer Medicare supplemental insurance options than seniors in other states.

77 Million Baby Boomers to Enter Medicare



Source: Centers for Medicare and Medicaid Services

Future Medicare Problems Loom Larger for Wisconsin

In the absence of Congressional action to fundamentally change the Medicare system, these significant problems pose serious threats to Medicare nationwide, especially in Wisconsin.

Limited Access

On March 17th, 2002, the New York Times reported that not only are providers concerned with reimbursement rates, but some have begun to act on those concerns by refusing to accept new Medicare patients. While threats have been made for several years, this marks the first reporting of actual refusal of Medicare patients.

In Wisconsin, the Wisconsin Medical Society issued a statement earlier this year indicating that reimbursement cuts as well as the increasing number of patients entering the Medicare pool will create serious access problems in the near future. At the same time, Bellin Hospital announced a reduction of 70 jobs citing poor Medicare Reimbursement as a primary reason for the layoff.

Without a change to the system, a "perfect storm" situation is developing for Medicare access in Wisconsin. Wisconsin's combination of a higher percentage of Medicare recipients and a lower ratio of participating physicians than the national average, along with a reimbursement rate among the lowest in the nation, could develop into a statewide crisis. Rural areas will be hit the hardest.

An Increase in Wisconsin's Uninsured

In order to make up for low Medicare reimbursement rates, a cost-shift to the commercial population must occur. Increases in physician and hospital charges have been widely reported as a leading factor in the rise in health insurance costs. However, the inadequate Medicare reimbursement is a leading factor in the increases in provider charges.

It has also been widely reported that employers, especially small businesses in Wisconsin, can no longer sustain the double-digit increases in health insurance premiums that have been seen in the state recently. Because the economy is now tighter than in previous years, employers who are unable to absorb premium increases have begun to require their employees to pick up a larger share of their own health insurance costs.

If rising health care costs and other factors continue to drive up health insurance premiums, employers may decide to drop coverage for their employees altogether. While some who lose coverage may find it in the individual market or with a spouse's group, others will simply forgo coverage -- either because it is unaffordable or because they don't understand the consequences of not having health insurance.

Wisconsin takes pride in having one of the lowest rates of uninsured residents in the nation. A report released in May 2002 by the Institute of Medicine indicated that being uninsured for even one year can diminish a person's general health. The consequences for the state are clear.

An increase in uninsured would have a detrimental impact on the health of many Wisconsin citizens that in the long-term would potentially feed the cycle by driving up health care costs once again. In addition, it could lead to a significant rise in the use of government programs such as BadgerCare or Medicaid, thus requiring additional funding from Wisconsin taxpayers.

Financial Insolvency for Medicare

Nationwide, by 2010, the number of Medicare beneficiaries is projected to begin rising faster that the number of workers contributing to the Medicare program due to the baby-boom generation reaching retirement age. According to the 1999 Medicare Trustees Report, by 2025, assuming no changes in eligibility, the number of beneficiaries will increase by approximately 77% from 40 million to approximately 70 million recipients. This will place enormous financial pressure on the Medicare system.

The future is bleak. Medicare spending is expected to rise from 2.5% of Gross Domestic Product to more than 4% in 2025. Medicare Part A is expected to become insolvent in the same year.

While not specific to Wisconsin, state data indicate that the problem will be significant within its borders. According to 1999 Wisconsin Workforce Development data, the number of workers per Medicare beneficiary in many Wisconsin counties has decreased from 3.7 at the time of inception to below 3.0 and is projected to decrease further, especially in rural counties.

An Aging Population

By the year 2025, CMS estimates that nearly 21% of Wisconsin's population will be over the age of 65, compared to 15% in 1998. Allowing the Medicare reimbursement formula to exist in its current form, will guarantee even greater cost shifting, unending double-digit health insurance premium increases, increased numbers of uninsured residents, continued decrease in physicians accepting Medicare patients, and fewer hospitals.

Moving Forward

Fighting for Fairness

It is clear that Wisconsin continues to receive inadequate Medicare funding compared to the dollars it contributes to the program. The current and projected problems that result from this underfunding are also apparent. Therefore, it is critical to establish and carry out an aggressive, multi-faceted course of action to correct the system.

Fighting Over the Pie

With significant Medicare problems facing Wisconsin, it is crucial for all providers, insurers, businesses and beneficiaries to work together to help find and achieve solutions.

The Bush Administration's current position is to require that any increase in Medicare payments to some health care providers must be offset by cuts elsewhere in the Medicare program. Without increasing the size of the Medicare pie, interested parties are pitted against one another. Significant resources are expended lobbying the federal Government over pieces of the pie, hampering efforts to fix the system and adding to the costs that are shifted to private payers. The philosophy of budget neutrality should only be expressed in terms of spending per beneficiary. The goal for the Bush Administration should be as it exists with the Medicare taxes they collect: equality in spending per beneficiary.

Public & Media Pressure

Wisconsin's news media can play a crucial role in addressing this issue by focusing more attention on the current inequity in the Medicare system and by emphasizing that the funding Wisconsin receives is far less than the amount of dollars that Wisconsin residents contribute to the Medicare program. The coverage should illustrate clearly the impact that this funding shortfall has on all citizens in the state.

Wisconsin newspapers, through editorials, opinion columns, and public forums, are strongly encouraged to advocate for changes to the Medicare System by raising public awareness and encouraging public involvement. Widening the chorus of voices would allow Wisconsin to receive fair reimbursement for Medicare services. They should also encourage the public to contact the Wisconsin Congressional delegation to express support for such changes and to emphasize the importance of this issue.

Mobilization of Stakeholders

The first step in a mass mobilization of concerned stakeholders is for them to understand the gravity of the issue and make Medicare reimbursement fairness a priority issue in 2003.

Stakeholders should then educate and activate any memberships organizations they participate in to contact the Wisconsin Congressional delegation to emphasize the importance of the issue and the further negative impact it will have on health care in Wisconsin if the status quo continues. This effort would coincide with direct lobbying and public relations efforts.

Stakeholders can also help continue the momentum generated by the state Medicare Reimbursement Summit by creating a statewide coalition to address the problem. Not only will a coalition make their efforts more efficient and effective, but it will also enhance publicity and send a message that Wisconsin is united in its effort to create a fairer system. However, in order to be effective, the coalition will need to meet regularly, establish a set of clear and concise goals, and implement a strategic plan and timetable to achieve those goals.

Stakeholders should communicate regularly with sister membership organizations in other states that have similar concerns with the Medicare system in order to share information and to actively pursue the creation of an interstate regional coalition.

Finally stakeholders can seek opportunities to testify before Congress to provide information and increase public awareness of the problem nationwide.

The Business Community as a Vital Stakeholder

Congressman Paul Ryan raised a significant point during the April summit: Congressional leaders and members have heard from almost all the "players" about Medicare reimbursement inequities, however, one group largely unheard from has been the business leaders in their Congressional districts. As businesses see the cost of health care consuming more and more of their scarce resources, they begin to understand how a 35-year-old formula could cost them growth opportunities or their livelihoods.

All businesses pay the same Medicare tax rate. All of their employees pay the same Medicare tax rate. Yet when businesses are cost shifted against from underfunded Medicare reimbursements it represents a hidden second Medicare tax which adds to Wisconsin's heavy tax burden. They are essentially subsidizing the delivery of Medicare in California, Texas, Florida and Washington, D.C. It is vital that businesses and their professional organizations begin to add their voices to efforts to lobby their Congressional representatives either one on one, or collectively through member organizations.

State Government

State legislators should be encouraged to send a united bipartisan message to the federal government demanding that Wisconsin receive fair Medicare reimbursement by passing a Joint Resolution at the beginning of the 2003-04 Legislative Session. The resolution should encourage Wisconsin's Congressional delegation to seek required changes to the Medicare reimbursement system.

In an effort to complement the resolution, State Legislators could also send a joint letter to the members of the Wisconsin Congressional delegation emphasizing the problems derived from the funding shortfall, the need for an immediate change and their support in achieving this goal. The letter should also be distributed to state news media outlets.

Members of the Legislature should be asked to communicate with their peers in other similarly situated states, either individually or through their member organizations, to give collective voice to the inherent unfairness with which Medicare taxes are collected and distributed.

The Governor of Wisconsin and his administration have been vocal on the subject of equity in Medicare reimbursements. The Governor should continue to send a clear message to the Wisconsin Congressional delegation and the Executive Branch that it is vital for Wisconsin's seniors, providers, hospitals, businesses and taxpayers that Wisconsin receive a fair Medicare reimbursement that focuses less on antiquated geographic divisions and assumptions, and focuses more on equitable distribution among beneficiaries and a more realistic approach to cost recovery for providers.

The Medicare Summit Planning Group members should continue to meet and decide on the next step to bring together coalitions and continue to advocate for equity for Wisconsin's Medicare beneficiaries, taxpayers and health care providers.